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June 13, 2005

TO: Each Supervisor

FROM: Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer
Department of Health Services

J. Tyler McCauley
Auditor-Controller

SUBJECT: REVIEW OF NAVIGANT CONSULTING INC.'S CONTRACT DELIVERABLES

The Department of Health Services Audit and Compliance Division (A&CD) and the Auditor-Controller have completed a review of Navigant Consulting, Inc.'s, (Navigant) compliance with its contract for consultant services at King/Drew Medical Center (KDMC). Our review was intended to assess Navigant's progress in completing the contract deliverables and implementing the recommendations made during Navigant's facility-wide assessment in January 2005. The review included interviewing various Navigant staff, Department of Health Services (DHS) and KDMC management and staff, reviewing documentation, and performing test work to validate progress.

Background and Summary

Based on issues raised by the Federal Centers for Medicare and Medicaid Services, DHS contracted with Navigant to provide interim management services and a facility-wide assessment at KDMC. The contract included a total of 35 contract deliverables. In addition, Navigant's facility-wide assessment included 1,066 recommendations. The maximum obligation of the contract between the County and Navigant, including the May 2005 amendment, totals approximately $15 million. We reviewed a total of 13 contract deliverables and noted that Navigant has fully implemented seven (54 percent) of the deliverables. The remaining six deliverables (46 percent) are in progress.

It should be noted that some of the in progress deliverables are ongoing and require Navigant to work towards implementation throughout the contract term. We also reviewed 56 assessment recommendations identified as "Urgent" in the assessment. These recommendations were supposed to have been implemented by February 28, 2005. We noted that 39 recommendations (70 percent) have been implemented, 15 recommendations (27 percent) have been partially implemented, one recommendation (two percent) has not been implemented, and one recommendation (two percent) was determined to be not applicable. The status of the deliverables and recommendations is as of the May 20, 2005, end of the audit period.

Conclusion

Navigant has made progress toward implementing the contract deliverables and the assessment recommendations. However, the audit points to a number of weaknesses that require immediate attention. DHS believes that implementation of the contract deliverables and assessment recommendations are critical to the turnaround of the hospital. To this end DHS will work closely with Navigant to develop a plan of correction to address the issues identified in the audit. DHS A&CD and the Auditor-Controller will continue to monitor Navigant's progress during its engagement.

Details of our findings and recommendations are included in the attached report. A copy of this audit has been provided to the KDMC Hospital Advisory Board for its review.

Please let us know if you have any questions.

TLG/JTM:sr

Attachment

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors
Navigant Consulting, Inc.

LOS ANGELES COUNTY – DEPARTMENT OF HEALTH SERVICES

AUDIT AND COMPLIANCE DIVISION

- AND -

LOS ANGELES COUNTY AUDITOR-CONTROLLER

SUBJECT: REVIEW OF CONTRACT DELIVERABLES - NAVIGANT CONSULTING, INC.

PURPOSE/BACKGROUND:

Based on issues raised by the Federal Centers for Medicare and Medicaid Services, the County Department of Health Services (DHS) contracted with Navigant Consulting, Inc. (Navigant) to provide interim management services and a facility-wide assessment at King/Drew Medical Center (KDMC). The contract between Navigant and DHS, including the May amendment, is for approximately $15 million. The interim management services included providing on-site management, such as a Chief Executive Officer, Chief Operating Officer, Chief Nursing Director, and other key management positions. The facility-wide assessment included developing and implementing recommendations to correct clinical and operational deficiencies at KDMC. The contract stipulates that the Chief Operating Officer (COO) of the Department of Health Services (DHS) will monitor Navigant's performance to ensure obligations under the agreement have been met and review all tasks, deliverables, goods, services, and other work provided by or on behalf of Navigant.

In accordance with the contract, Navigant developed a detailed action plan [workplan] to address deficiencies or inefficiencies identified in its assessment of KDMC systems and operations. Navigant identified 1,066 recommendations in the workplan. Navigant indicated that, as of April 1, 2005, 275 (26%) of the recommendations had been completed. Navigant also reported that the 275 completed recommendations included 190 (84%) of the 225 recommendations that were classified as Urgent. The deadline specified by Navigant for completion of Urgent recommendations was February 28, 2005.

SCOPE/METHODOLOGY:

DHS' Audit and Compliance Division (A&CD) worked in conjunction with the Auditor-Controller to review the contract deliverables identified in the Statement of Work (SOW) for Interim Management Services and Assessment of KDMC systems and operations, including 13 of the 35 (37%) judgmentally selected deliverables specified in the SOW.

In addition, A&CD and the Auditor-Controller judgmentally selected 44 (20%) of the 225 Urgent recommendations from Navigant's workplan to verify that the recommendations were implemented. There were 156 associated action steps detailed in Navigant's workplan for these 44 recommendations, with completion dates for the action steps due between December 2004 and April 2005, which were reviewed to verify that the action had been completed as indicated in

the workplan. The preliminary outcome of the selected sample identified an implementation rate lower than expected, therefore, A&CD and the Auditor-Controller selected 12 additional recommendations for review, for a total sample of 56 (25%) recommendations and 192 action steps. Seven of the 56 recommendations were identified as "not implemented" on Navigant's workplan, but were due to have been implemented by February 28, 2005.

A&CD and the Auditor-Controller interviewed Navigant, Human Resources, DHS Administration, and KDMC employees and reviewed relevant and available documents to support the actions completed.

REVIEW OF CONTRACT DELIVERABLES

Task 1 of the SOW indicates that Navigant is responsible for overseeing the day to day operations of the Hospital, in consultation with the DHS Director, DHS COO and KDMC Chief Medical Officer. Task 2 requires Navigant to conduct an assessment and concurrent implementation of services for improvements in the operations and delivery of health services throughout the hospital. The following sections are the A&CD's and Auditor-Controller's findings for the deliverables reviewed.

- **Deliverable 1.1**

  Requires Navigant to provide full-time, on site Chief Executive Officer, Chief Operations Officer, Chief Nursing Officer, Physician Advisor, Senior Pharmacies Consultant, Senior Laboratory Consultant, Senior Medical Records Consultant, Human Resources Specialist, and various nurse managers.

  Status: **In Progress**

  Auditor-Controller's Finding

  Auditor-Controller staff interviewed DHS and Navigant management, performed walk-throughs at KDMC, and reviewed contract invoices and other relevant documents to determine whether Navigant provided the required staffing. The Auditor-Controller noted instances where Navigant did not appear to always provide the required full-time, on-site staff. For example, some Navigant staff were off-site or on vacation at various times. The Auditor-Controller also reviewed Navigant's invoices from November 2004 through April 2005 and noted that Navigant billed DHS the total monthly contract fee with no adjustments for any staff absences.

  Navigant indicated that any instances of reduced staffing were fully offset by additional staffing at other times and/or other areas for which Navigant did not bill the County. Navigant indicated that, within the next 30 days, they will provide DHS with a reconciliation of all the Navigant staff to document that they provided the required staffing. DHS management will review the reconciliation to ensure that Navigant met the required staffing levels.

  It should be noted that Navigant and DHS have been working under the assumptions contained in the recent amendment to the contract approved by the Board. This allows DHS to strengthen the monitoring process by requiring Navigant to provide an itemized invoice listing the total cost of each position, along with a certification signed by Navigant's Project Director attesting to the level of services provided. Although the amendment requires Navigant to maintain documentation supporting the certification, it does not address the type of documentation that should be maintained (e.g., attendance logs, timecards, etc.).

Recommendation
In order to more effectively monitor Navigant's interim management positions, DHS should require Navigant to submit the supporting documentation along with the certification to ensure that the documentation adequately supports the level of services provided.

- Deliverable 1.2

Establish a process pursuant to which the interim management team will meet on a regular and frequent basis with the Director of DHS and the Chief Operating Officer of DHS to report on operational activities at the Hospital, to obtain approval for significant policy modifications and direction on other policy initiatives, and to seek information and assistance, an necessary, in achieving Task One objectives.

Status: **Implemented**

Audit and Compliance Division's Finding
DHS Administration confirmed that the DHS Director and DHS COO and other senior managers have a conference call with Navigant at least three days each week and a weekly meeting to discuss operational issues. The topics include a summary of daily census and any clinical issues of concern, human resources activity, clinical event reporting and evaluation, contracting issues, and staffing issues. These calls and meetings allow DHS to request and obtain information from Navigant, provide direction, and observe their progress. Additionally, there is frequent daily communication with Navigant staff on specific issues with individuals assigned as DHS contacts.

- Deliverable 1.5

By March 1, 2005, develop and implement a transition plan that replaces Contractors' interim managers with permanent managers so that the corrections can be sustained.

Status: **In Progress**

Audit and Compliance Division's Finding
Navigant provided documentation of the status of recruitment for management and executive positions. Without the timing of replacements or background of replacements being known, Navigant indicated that it was premature to develop a transition plan. Once the replacement executives are hired, Navigant will provide a specific transition plan based on the remaining improvements to be completed, and the replacements' level of experience. The County Department of Human Resources (HR) also indicated that there have been on-going discussions and meetings related to the recruitment process.

Recommendation
Navigant should continue to work with County HR to recruit for permanent managers and ensure that the specific transition plans are developed for each new permanent manager once they are recruited.

- Deliverable 1.7

By March 1, 2005, identify gaps in mid-level management positions. In consultation with DHS' HR staff, recruit, interview, and make recommendations for hire to the County for positions necessary to fill the management gaps.

Status: **In Progress**

Audit and Compliance Division's Finding
The approved amendment to the contract clarified expectations that recruitment would be completed by September 1, 2005. Navigant has met with DHS Management and County HR to discuss mid-level management staffing. In the recent contract amendment, Navigant identified additional management staff required to address the recommendations and workplans developed as part of the Assessment. Navigant and the County are currently conducting a nationwide recruitment campaign for nurse managers and nursing directors. As of May 26, 2005, these positions have not been filled.

Recommendation
Navigant should continue to work with County HR to recruit, interview, and make recommendations to hire for the identified management positions.

- Deliverable 1.8

By February 1, 2005, restructure the medical staff office.

Status: **Implemented**

Auditor-Controller's Finding
The Auditor's review of the medical office organizational charts and interviews with Navigant and DHS managers indicates that significant changes have been made in Hospital Administration, Medical Administration, Nursing Services, and Hospital Operations organization structures. Specifically, the organization structures have been reorganized to provide more management staff and a higher degree of oversight in the Nursing Services and Medical Administration Units.

The recent amendment to the contract included funding for five additional nurse managers to be provided by Navigant. These positions were phased in and were intended to increase management oversight in Nursing Services.

- Deliverable 1.9

By February 1, 2005, review Medical Staff's compliance with medical staff bylaws and submit written recommendations for necessary changes.

Status: **Implemented**

Auditor-Controller's Finding
Navigant's facility-wide assessment included several recommendations related to the medical staff's regulatory compliance. The Board of Supervisors approved the revised bylaws for the KDMC Professional Staff Association (PSA) in January 2005. Navigant has provided copies of the revised bylaws and training to all medical staff.

Recommendation
Navigant develop a mechanism to ensure that the Chief Medical Officer and Department Chiefs monitor physicians' compliance with the revised bylaws.

- Deliverable 1.11

By March 15, 2005, recommend and implement new credentialing and privileging processes and confirm all physician credentials.

Status: **Implemented**

Auditor-Controller's Finding
Navigant's facility-wide assessment included eight recommendations to improve physician credentialing and privileging. The Auditor noted several new KDMC policies and procedures related to the credentialing and privileging process.

In addition, Navigant and KDMC are using the Computer Assisted Credentialing Tracking Update System (CACTUS) to certify physician credentials and privileging. The Auditor's comparison of the information on CACTUS to the personnel files for five physicians indicated that the credentialing and privileging information was generally accurate.

- Deliverable 1.12

Recommend and implement a system for implementation, oversight, and reporting corrective actions for any significant or peer reviewed clinical events.

Status: **In Progress**

Audit and Compliance Division's Finding
Navigant identified mechanisms that have been or are being developed to identify issues and provide oversight throughout the hospital, such as Executive Patient Safety Walk-rounds, Clinical Pertinence Review, and Clinical Assistant Team (CAT) Rounds. In addition, Navigant provided a summary of patient charts that were reviewed and determined to be significant events that were referred for further root cause analysis. However, A&CD noted that required reports/notifications on sentinel events are not provided to DHS Administration. DHS Administration confirmed that deaths are identified by Navigant in a daily conference call, but does not include a report of a review of the death in terms of the clinical care. Navigant has since been requested to formally adopt a process to report cases subsequently identified as critical events or sentinel events that should undergo root cause analysis.

Recommendation
Navigant ensure that required reports/notifications on sentinel events are reported to DHS Administration as required.

- Deliverable 1.13

Throughout the duration of the Agreement, assure that root cause analyses are conducted on all incidents determined to be significant events. Make and implement recommendations to address and resolve personnel and systems issues uncovered by the root cause analyses.

Status: In Progress

Auditor-Controller's Finding
Navigant was involved in approximately 30 root cause analyses of significant events. Navigant participated in making and implementing recommendations to address personnel and systems issues uncovered by the root cause analyses. However as noted under Deliverable 1.12 above, although Navigant has been involved in root cause analyses, required reports/notification on sentinel events are not provided to DHS Administration. Navigant has since been requested to formally adopt a process to report cases subsequently identified as critical events or sentinel events that should undergo root cause analysis.

Recommendation
Navigant ensure that required reports/notifications including root cause analyses are reported to DHS Administration as required.

- Deliverable 1.14

By February 1, 2005, provide a detailed, written recommendation as to the appropriate mix/scope of clinical services to be offered at KDMC Medical Center.

Status: Implemented

Auditor-Controller's Finding
Navigant's Assessment Report included 49 recommendations related to changes in specific clinical services. The recommendations addressed areas such as changes to services to meet community need, manpower planning needs, and some facility/space issues. The Department and Navigant agree that further assessment of the scope and mix of services provided at the hospital will be necessary and that this work will continue on an on-going basis throughout the term of this engagement.

Recommendation
Navigant continue to work with DHS on a detailed assessment of the overall mix and scope of clinical services to be provided at KDMC.

- **Deliverable 1.17**

  Develop by January 17, 2005, a new Performance Improvement Program, to comply with Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) National Patient Safety Goals, and, after receiving approval from the County Project Director, work toward implementation of this plan. Contractor shall ensure appropriate involvement of physicians in Performance Improvement Program activities.

  Status: **In Progress**

  Auditor-Controller's Finding
  Navigant's facility-wide assessment included several recommendations related to JCAHO performance improvement and compliance. In addition, Navigant provided documentation addressing JCAHO's 2005 Patient Safety Goals. Navigant is also continuing to work on drafting and updating policies to ensure full compliance with JCAHO requirements.

  Recommendation
  Navigant should continue to work toward the implementation of 2005 National Patient Safety Goals to ensure compliance with JCAHO requirements.

- **Deliverable 2.1**
  By January 3, 2005, provide a comprehensive written Assessment Plan, including recommendations as to how to remedy each deficiency, inefficiency, and area of concern and include recommendations for staffing the remediation efforts as well as an estimated timeline for implementation of the recommendations.

  Status: **Implemented**

  Audit and Compliance Division's Finding
  Navigant completed a comprehensive Assessment Plan, identifying deficiencies and inefficiencies and an estimated timeline for implementation. The Auditor-Controller and A&CD completed a review of a sample of the workplan recommendations to determine if recommendations had been implemented. The results of the review are included in the latter part of this report.

- **Deliverable 2.2**
  Periodic progress reports at intervals not to exceed 60 days, describing and evaluating all remedial actions taken by the Hospital and, where appropriate, recommending additions and other amendments to the Contractor's initial Assessment Plan.

  Status: **Implemented**

  Audit and Compliance Division's Finding
  Navigant provides periodic progress reports of the corrective actions identified in the Assessment workplan as required.

CONCLUSIONS:

1. The Auditor-Controller and A&CD reviewed 13 (37%) of the 35 deliverables. Seven (54%) of the deliverables have been implemented and six (46%) are in progress.

2. Based on the documents reviewed, Navigant has not appeared to provide the required full-time, on-site staff. Although Navigant indicated that they provided staff at other times to meet the required staffing levels, DHS management will review the reconciliation to ensure that Navigant met the required contract staffing levels.

3. Navigant communicates with DHS Administration on a routine basis and continues to work with DHS and County HR to recruit for permanent Executive and Management positions to sustain implemented corrective actions at KDMC.

4. Weaknesses were noted in Navigant's monitoring to ensure compliance with implemented changes and reporting of corrective actions to DHS for significant or peer reviewed clinical events.

REVIEW OF ASSESSMENT WORKPLAN

Navigant monitors the progress/status of all the recommendations from their initial assessment. A&CD and the Auditor-Controller reviewed the status of 56 (25%) of the 225 recommendations and 192 associated action steps that Navigant should have completed by February 28, 2005.

Navigant informed A&CD that the status of recommendations is updated monthly based on information provided by the assigned lead person. Navigant stated that, occasionally upon further review, it may be determined that the status of the recommendations should be modified. For example, Navigant reported that 285 recommendations had been completed as of March 4, 2005. However, between March 4 and April 1, 2005, 26 recommendations were "Reversed" and Navigant indicated that only 259 should have been reported as implemented.

The following is the detailed status of the 18 recommendations and action steps that have only been partially implemented or have not been implemented. Not included are the details for the recommendations that have been fully implemented.

- **Recommendation S02-I03-R003**
  Review and revise the incident reporting policies and procedures.

  Status: **Partially Implemented**

  Action Steps

  1. Develop procedure for collecting incident reports. (Partially Implemented; see finding below)

     Audit and Compliance Division's Finding
     KDMC's Risk Management provided a revised policy for incident reporting, effective February 8, 2005. The policy was revised again in April 2005 to include sentinel event notification, but the policy had not been approved. A&CD conducted random interviews with nine KDMC clinical staff including three physicians, one nurse manager, two supervising staff nurses, one staff nurse, and two Licensed Vocational Nurses who indicated that incidents should be reported to the units' supervisors. However, all the staff indicated that they were not aware the policy had been revised or of any changes in the process.

     Navigant stated that, although some staff may not be aware of the revised reporting policy, incident forms have been submitted consistent with the established procedures. In addition, Navigant indicated incident reporting is supplemented by Clinical Assessment Teams (CAT), which include doctors and nurses, to conduct rounds of the facility and follow up on incidents as they occur.

  2. Develop procedure for reviewing reports centrally, and capturing and categorizing issues. (Partially Implemented; see finding below)

Audit and Compliance Division's Finding

Risk Management staff indicated that they enter the incident into the Hospital's Affinity computer system and a report can be generated by the unit. However, Risk Management staff indicated that there is approximately a two-month lag time in inputting incident reports into the system, while KDMC's policy indicates that the data will be entered from the Event Notification Report within one business day. Navigant's Advisor to the Medical Director informed DHS Quality Improvement Program (QIP) staff that she was beginning to develop a system for capturing and categorizing issues.

Subsequent to A&CD's initial review, Navigant provided a report of Performance Measures identified by type of incident for January through March 2005. Navigant indicated that the data was taken from the Incident Reports that have been input into Affinity and is reviewed by the Quality Control Board. It appears that a system to track incidents has been developed. However, a formal process for reporting critical or sentinel events to DHS Administration has not been implemented.

- **Recommendation S02-I05-R001**

Develop a quality oversight committee of the Board.

Status: **Partially Implemented**

Action Steps

1. Define structure for quality oversight committee and membership. (Implemented)
2. Systemize accountability for Board. (Partially Implemented; see finding below)
3. Develop committee charter. (Partially Implemented; see finding below)
4. Define membership categories. (Implemented)
5. Recommended quality oversight committee structure to advisory board. (Implemented)
6. Advisory board to identify and recruit committee members. (Implemented)

Audit and Compliance Division's Finding

Navigant staff provided a draft organizational structure and membership policy for the quality oversight committee dated March 20, 2005. Navigant initially indicated that no action has been taken to systemize accountability for the Board. However, Navigant subsequently indicated that the Quality Committee's charge and priorities were discussed at the Hospital Advisory Board's (HAB) May 9, 2005 meeting. The agenda included the item for discussion. However, the meeting minutes have not been transcribed as of June 1, 2005. The first Quality Committee meeting was held on May 27, 2005 and included an agenda item to discuss the committee's responsibilities. The next HAB meeting is scheduled June 13, 2005. Therefore, it appears that Action Steps 2-3 are in progress.

- **Recommendation S02-I05-R002**

At a minimum, revise Improve Organization Performance (IOP) Committee membership to a 15-member group that assesses departmental Performance Improvement (PI) reports.

Status: **Partially Implemented**

Action Steps

1. Explore feasibility of integrating quality oversight committee of board with current committee. (Implemented)
2. Review current bylaws. (Implemented)
3. Ensure structure is consistent with bylaws. (Partially Implemented; see finding below)

Audit and Compliance Division's Finding
Navigant staff provided documentation indicating that a Navigant Medical Advisor, met with the Medical Executive Committee in May 2005. However, they did not discuss amendments to the bylaws in order to be consistent with the committee structure. Navigant also provided correspondence with County Counsel which indicates that the committee's structure is being reviewed to determine if the organization is legally appropriate. County Counsel confirmed that they are currently reviewing the organization structure.

4. Propose amendment to bylaws if required. (Not Implemented; see finding below)
5. Obtain medical staff approval on amended bylaws. (Not Implemented; see finding below)
6. Obtain Board of Supervisors, DHS and Advisory Board's approval on amended bylaws as required. (Not Implemented; see finding below)

Audit and Compliance Division's Finding
Bylaws have not been revised, pending the results of the May 2005 Medical Executive Committee meeting.

➢ Recommendation S02-I05-R007
Establish a PI manager role to facilitate oversight of department functions.

Status: **Partially Implemented**

Action Steps

1. Interim Director of Performance Improvement to assume this role. (Partially Implemented; see finding below)

Audit and Compliance Division's Finding
Navigant indicated that one Navigant staff was in this role for approximately 2-4 weeks. However, a March 15, 2005 draft of the Medical Administration Organization chart, lists a different Navigant consultant as the Interim Director of Quality Management and Performance Improvement and Throughput. Navigant indicated that the consultant listed on the March 15, 2005 draft would resume the duties for this function on June 6, 2005.

➢ Recommendation S02-I06-R002
Develop a succinct Infection Control Plan and obtain approval by the Infectious Disease Control and Prevention Committee.

Status: **Partially Implemented**

Action Steps

1. Complete final review and revisions of Infection Control Plan draft. (Implemented)
2. Present final drafts to Infection Control Committee for comment and/or approval. (Implemented)
3. Make revisions to draft as indicated. (Implemented)
4. Present final draft to Medical Executive Committee for comment and/or approval. (Implemented)
5. Complete final revisions as indicated. (Implemented)
6. Obtain final approval for Infection Control Plan with all revisions. (Implemented)
7. Roll-out final Infection Control Plan. (Partially Implemented; see finding below)

Audit and Compliance Division's Finding

An Infection Control Plan has been submitted to members of the Infectious Disease Control and Prevention Committee. However, it has not been disseminated to all departments. A&CD was informed that once the Infection Control binders have been revised, they will be sent to all departments. Elements of the Infection Control Plan have been discussed in the PSA meetings at which time nurse managers and department heads had an opportunity to provide input. Navigant also provided documentation regarding an Infection Control Fair held on May 25, 2005, which was intended as the "overall kick-off" for the plan.

➢ Recommendation S02-I11-R002

Develop an annual plan for in-service education for nurses and others regarding monitoring equipment. Involve Medical Equipment (ME) manager with all ME contract activities to assure a consistent program/compliance.

Status: **Partially Implemented**

Action Steps

1. Identify nursing units and other departments responsible for monitoring equipment and report departments/services in violation of the incoming ME policy. (Not Implemented; see finding below)
3. Develop a plan for timing clinical staff training. (Not Implemented; see finding below)

Audit and Compliance Division's Finding

Navigant indicated that staff is in the process of identifying the units and timing of training. However, no documentation was provided to support implementation.

2. Identify violations and training requirements. (Partially Implemented; see finding below)
4. Submit training plan to clinical executives for approval. (Partially Implemented; see finding below)

5. Roll-out training. (Partially Implemented; see finding below)
6. Monitor attendance and incorporate proficiency in performance evaluations. (Partially Implemented; see finding below)

Audit and Compliance Division's Finding
KDMC's Facilities Manager and Biomedical Engineer indicated that they had submitted a proposal for ME in-service education to Navigant's ICU Nurse Manager and are waiting for approval. The proposal includes a number of training modules. Training for module E (*Preventing Hypothermia in Hospitalized Patients*) has been started, since it was approved last year prior to Navigant's recommendations. Modules A and B were approved on April 13, 2005, according to an April 18, 2005 memo. Navigant subsequently provided documentation indicating two nursing staff have attended training on Module A, Basic Principles of Patient Monitoring.

➢ Recommendation S03-I01-R023
Initiate daily huddles between case manager, social worker and Nursing to briefly discuss each patient, plan of care and any identified needs.

Status: **Partially Implemented**

Action Steps

1. Develop policies and process to define participation, goals, and responsibilities. (Implemented)
2. Identify pilot site. (Implemented)
3. Initiate huddle on pilot site. (Implemented)
4. Evaluate success and adjust process as necessary. (Partially Implemented; see finding below)
5. Develop a plan for roll-out to all clinical units and implement. (Not Implemented; see finding below)

Audit and Compliance Division's Finding
Navigant provided A&CD with Care Coordination Rounds Guidelines and a draft Care Management Future State Roles and Responsibilities. KDMC staff indicated that two areas were identified for "daily huddles": Telemetry and Trauma ICU. A Nursing Care Specialist I and a Utilization Review Nurse who have worked in the ICU indicated that Navigant verbally advised staff in January and February 2005 that "huddles" would be held for no more than 15 minutes a day to discuss patient status and movement of the patient from the ICU. One nurse indicated that Navigant developed a form to be used for notations during the huddle, but was unable to provide a copy. These huddles were initially conducted Monday through Friday, but stopped in mid-March and are no longer continued. KDMC staff indicated that feedback and follow-up were not provided regarding the huddles. As a result, the physicians reverted to the pre-Navigant patient rounds, which are conducted every Wednesday, including weekly discharge rounds and meetings as needed.

Following our review, Navigant indicated that the process was reevaluated and has since reversed its prior implementation status as of April 29, 2005 to indicate not fully implemented.

- Recommendation S03-I02-R001
  Establish baseline performance metrics for admission process.

  Status: **Partially Implemented**

  Action Steps

  1. Define performance metrics. (Implemented)
  2. Collect data for baseline period. (Implemented)
  3. Complete baseline data analysis. (Implemented)
  4. Communicate performance measures and baseline metrics to admitting staff personnel. (Not Implemented; see finding below)

  Audit and Compliance Division's Finding
  The Director of Hospital Social Services indicated that Utilization Management, Admissions/Registration, and Clinical Social Services were merged together as one unit, effective March 2, 2005. Staff indicated that daily "Bed Huddles" have been in place since approximately December 2004 to discuss staffing, bed availability, capacity for all shifts, pending discharges, and patient count in the emergency room, which have been helpful in determining bed availability and staff support. However, staff was not aware of any identified performance metrics for the admission process and could not validate the methodology or accuracy of information reported by Navigant.

  Navigant subsequently provided a report of Performance Measures captured for Capacity and Throughput that included data for eight of the eleven metrics identified of which five included only one month's data. In May 2005, a Navigant staff was assigned the responsibility for completion of this recommendation. The Navigant staff and KDMC Admissions staff were previously unaware of the action steps that need to be implemented.

- Recommendation S03-I03-R042
  Perform monthly concurrent chart review of deaths.

  Status: **Partially Implemented**

  Action Steps

  1. Identify if there is a process in place to track trauma related deaths. (Implemented)
  2. Review Trauma Deaths and Emergency Department (ED) deaths at the monthly ED Multidisciplinary meeting. (Partially Implemented; see finding below)
  3. Measurement. (Partially Implemented; see finding below)

Audit and Compliance Division's Finding

The Navigant Consultant assigned as Nursing Director of ED indicated that deaths are reviewed in monthly staff meetings as documented on the agendas and meeting minutes. The Consultant indicated that these meetings were in place prior to Navigant's arrival and are ongoing. In addition, she indicated that all deaths are reviewed by the ED's Quality Assurance physician, and discussed in the Multidisciplinary Team meeting. However, the KDMC ED Director indicated that not all ED and Trauma deaths are reviewed. Only deaths considered to be "fall outs" are reviewed, also specified in the Emergency Medicine Peer Review Policy, including cases with an adverse outcome including death, cases where medical staff identify problems with clinical performance, cases identified as below the standard of care, and cases referred by other departments/services. The ED committee that meets monthly does not review all deaths. DHS QIP indicated that the quality assurance physician does not review all deaths that occur in the ED.

- Recommendation S04-I02-R045

Complete residency supervision protocols by specialty by year and implement consistently.

Status: **Partially Implemented**

Action Steps

1. Review existing "Supervision of Residents" administration policy and revise as necessary to ensure that all overall resident supervision requirements are addressed from a regulatory standpoint. (Implemented)
2. Obtain necessary approval of revised "Supervision of Residents" administration policy from Medical Executive Committee and CEO. (Implemented)
3. Ensure that all necessary documentation of the "Supervision of Residents" policy revisions and their approval, including all signatures, is completed and filed according to protocol. (Implemented)
5. Work with individual department chairs to ensure that residency supervision protocols are outlined and finalized by specialty, by training year and include all supervision requirements as outlined in the "Supervision of Residents" administrative policy. (Partially Implemented; see finding below)
6. While developing supervision protocols, consider needs for implementing a monitoring process for the proctoring/supervision requirements. (Partially Implemented; see finding below)
7. Review and finalize, including any necessary approvals, all departmental residency supervision policies and procedures. (Partially Implemented; see finding below)
8. Following all necessary revision and approval, finalize documentation of new residency supervision policies and disseminate information, including effective date(s), to all necessary parties. (Partially Implemented; see finding below)

Audit and Compliance Division's Finding

As of the April Executive Committee meeting, KDMC's Supervision of Residents policy revisions have been drafted and submitted. Staff indicated that the policy is expected to be finalized by June 30, 2005. However, three of the residency programs' policies and

procedures were not available, and department specific policies and procedures need approval.

On May 20, 2005, Navigant provided a copy of the Supervision of Residents policy that had been signed on May 11, 2005. Therefore, Action Step 1-3 appear to have been implemented. In addition, Navigant provided a procedure list by specialty, which defines procedural competency levels by year. However, it does not include how those levels fit into the residency supervision matrix. The Supervision of Residents Policy indicates that each department's policy shall define the attending physicians' supervision responsibility and shall define the specific procedures, consultations or services required. Navigant provided documentation regarding Clinical Pertinence Reviews of medical charts for monitoring of supervision protocols and providing real-time behavior reinforcement in the interim. However, the documents provided indicated that the reviews have not occurred.

4. Distribute updated documents to chairs. (Not Implemented; see finding below)

Audit and Compliance Division's Finding
Policy has not been distributed to Department chairs, pending final approval.

➢ **Recommendation S04-I03-R005**
Define Medical Officer of the Day (MOD) role to include Physician Advisor responsibility for Utilization Management (UM) to work daily with Case Managers and Social Workers actively intervening with physicians to enhance care coordination. Charge role with responsibility of "clinical triage czar" to triage patients as most clinically appropriate among various Intensive Care Units (ICU), and other bed levels.

Status: **Partially Implemented**

Action Steps

1. Discuss specific roles and responsibilities needed for the MOD position. (Implemented)
2. Draft necessary job descriptions and/or other documentation needed to define the MOD roles and responsibilities. (Implemented)
3. Follow any necessary channels for approval, submission to HR, etc. and finalize all documentation related to the MOD roles and responsibilities. (Partially Implemented; see finding below)

Audit and Compliance Division's Finding
Navigant staff indicated that no further actions have been taken for approval of all documentation related to the MOD. The MOD policy included in the handbook indicates that it was revised in April 2005. However, a signed and approved policy was not provided. Therefore, it appears that the Action Step 3 has been partially implemented.

- **Recommendation S04-I03-R006**
  Appoint one or more individuals to fill the MOD role – more than one splitting the responsibility would seem preferable to ensure coverage. Some coverage to be provided by the additional Associate Medical Director (AMD) and Medical Director.

  Status: **Not Applicable.**

  Action Steps

  1. Identify individual(s) who are strong candidates for filling the MOD role. (Not Applicable; see finding below)
  2. Select specific individual(s) to fill the MOD role. (Not Applicable; see finding below)
  3. Determine start date/transition date for the individual(s) filling the MOD role and prepare an orientation plan designed to familiarize the individual(s) with duties and expectations. Not Applicable; see finding below)
  4. Complete orientation of individual(s) to roles and responsibilities and officially "activate" MOD(s). (Not Applicable; see finding below)

  Audit and Compliance Division's Finding
  Based on discussions with Navigant, the two KDMC physicians were acting as MOD prior to Navigant's arrival. No other individuals have been identified. A start date/transition date has not been determined and orientation plans have not been designed because there have been no changes in the physicians assigned to perform the MOD responsibilities. Navigant stated that they subsequently determined that additional equity in the scheduling of the MOD physicians was necessary but that hiring additional physicians was not required. Navigant and KDMC staff confirmed that the current MODs were given an orientation based on the April 2005 handbook.

- **Recommendation S05-I12-R001**
  Immediately order replacement Code Blue Pagers.

  Status: **Partially Implemented**

  Action Steps

  1. Identify number and type of pagers to be ordered. (Implemented)
  2. Place and receive order of new pagers. (Implemented)
  3. In-service Code Blue Team and Implement pagers. (Partially Implemented; see finding below)

  Audit and Compliance Division's Finding
  A&CD reviewed documentation of the staff assigned new Code Blue Pagers. However, Navigant indicated that a "new mix" for the Code Blue Team members has not been identified, therefore, pagers were provided to the existing Team members and in-service training has not occurred.

Navigant subsequently indicated that pagers are also periodically tested and provided a copy of results from the test. Navigant indicated that the Medical Director, as well as the management team, is responsible for monitoring the results of the tests and referring identified discrepancies to the responsible Department Chair. The Chair is responsible for following up and disciplining doctors who do not respond to the page. However, A&CD was unable to verify that follow-up of the testing occurs to ensure that appropriate action is taken with staff who do not respond.

- **Recommendation S06-I06-R006**
  Ensure Occupational Therapy is doing Activities of Daily Living Assessments.

  Status: **Not Implemented**

  Action Steps

  1. Following hiring of additional OTRs, develop plan to ensure that they are completing Activities of Daily Living Assessments when appropriate. (Not Implemented)

     Audit and Compliance Division's Finding
     Navigant staff indicated that that only one new staff was hired in Occupational Therapy since workplan implementation. The Interim Clinical Director of Psychiatric Services indicated that the new staff was familiar with the assessment tool and that they personally reviewed the section on Daily Living Assessments with the new staff. Navigant indicated that results have been positive. However, QIP reviewed a sample of 30 medical records and determined that while most contained documentation of nursing assessments, only one in 30 contained documentation of daily individual behavioral areas having been assessed by Occupational Therapy. Navigant performed a subsequent review of charts and was in agreement with the findings.

- **Recommendation S08-I06-R035**
  Implement Solutions to the patient privacy issues in the main file room.

  Status: **Partially Implemented**

  Action Steps

  1. Meet with Chief Operating Officer and plant operations to develop schedule for remodeling. (Partially Implemented; see finding below)
  2. Contact Plan Operations to determine schedule and budget. (Partially Implemented; see finding below)

     Audit and Compliance Division's Finding
     KDMC Plant Operations to developed a remodeling plan and a schedule. However, staff noted potential problem concerning fire codes. An evaluation and cost analysis was due to be completed by the end of April 2005. The original plan to remodel the area was

submitted for management approval. However, plant management was unable to locate a projected budget for the remodel plan.

3. Develop Schedule for moving furniture and equipment to visitor chart review area. (Not Implemented; see finding below)

   Audit and Compliance Division's Finding
   A schedule for moving furniture and equipment depends upon Plant Operations and completing the remodeling project or deciding to change the plan to an electronic filing system.

- **Recommendation S10-I03-R004**
  Revise process for analyzing patient safety issues; hold management team and staff accountable.

  Status: **Partially Implemented**

  Action Steps

  1. Work with Quality Management/Risk Management and Nursing to implement UHC *Patient Safety Net incident system.* (Not Implemented; see finding below)

     Audit and Compliance Division's Finding
     DHS' Director of Pharmacy (DOP) indicated that the purchase of the system is pending and implementation is scheduled for August 2005.

  2. Revise job descriptions/performance evaluation to include patient safety component(s). (Implemented)

- **Recommendation S10-I03-R030**
  Evaluate alternatives for improving quality, patient safety and service delivery, including outsourcing.

  Status: **Partially Implemented**

  Action Steps

  1. Hire Interim DOP. (Partially Implemented; see finding below)

     Audit and Compliance Division's Finding
     The former KDMC DOP has maintained the function until an interim DOP is hired. Interviews for four applicants have been scheduled for June 15, 2005.

  2. Create a Request for Proposal (RFP) for outsourcing the pharmacy department. (Partially Implemented; see finding below)

Audit and Compliance Division's Finding
Navigant submitted an initial draft RFP for review by DHS Management. However, it was returned to Navigant for revision. DHS Administration indicated that a meeting to discuss the documents and workload figures subsequently submitted by Navigant was held and DHS continues to work with Navigant regarding the County's solicitation process.

CONCLUSIONS:

5. Based on interviews of staff and documents reviewed, A&CD and Auditor-Controller verified that 31 (55%) of the 56 recommendations sampled were implemented as of April 27, 2005. Subsequently, Navigant provided additional information which increased the total number of implemented recommendations to 39 (70%) of the 56 sampled recommendations.

   Of the remaining 17 sampled recommendations, 15 were partially implemented, one was not implemented, and one was determined to be not applicable.

6. Based on interviews of staff and documents reviewed, A&CD and Auditor-Controller verified that 120 (63%) of 192 action steps were implemented as of April 27, 2005. Subsequently, Navigant provided additional information which increased the total number of implemented action steps to 153 (80%) of the 192 sampled action steps.

   Of the 39 of 192 action steps remaining, 24 were partially implemented, 11 were not implemented, and four were determined to be not applicable.

7. In many cases, implementation of the recommendations were initiated by a Navigant team member or a KDMC Senior Manager. However, actions were not finalized or disseminated to KDMC staff. It appears that Navigant did not follow-up to ensure recommendations were fully implemented.

8. Systems and processes may have been initiated as recommended in the Navigant report, but were not maintained and practices returned to those in place before Navigant's arrival.

9. Navigant did not retain documents at a level sufficient to demonstrate implementation or to maintain an adequate audit trail. Maintaining such an audit trail will assist Navigant in monitoring and ensuring full implementation of the recommended deliverables and will serve as a valuable tool in monitoring compliance.

RECOMMENDATION:

Navigant continue to work towards implementing all recommendations specified in its Assessment workplan and ensure that adequate follow-up and documentation is maintained.